2012 February column

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Ghana. I have returned to Africa after many years in Europe, and now I have a better understanding of what goes on. This month I will start with my perception about Ghana so far on issues of nutrition. Then I will summarise the themes of my 2011columns, as I did at the beginning of 2011 for 2010. This gives a good foundation of where we got to in 2011. Meanwhile, enjoy the beach scenery in Ghana above.

Maternal deaths in Ghana

Zero tolerance for death in childbirth

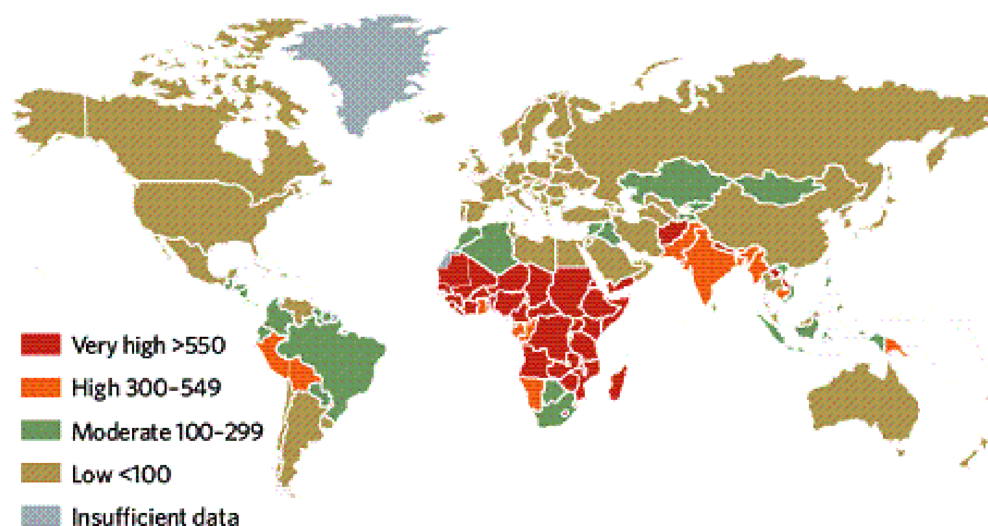
Annan R, Zero tolerance for death in childbirth, and other stories *[Column]*. *World Nutrition*, February 2012, **3**, 2

Ghana is an African country where progress is being made regarding democracy, governance, rule of law, accountability, female education, and nutrition. But progress is relative. Someone who is the richest among the poor may well not be rich. Or compare poorly performing high schools. and your school is the best among these. It may still not be good enough to compete with good schools. Progress may not be enough.

In Ghana, take maternal mortality – women who die from complications related to childbirth. There is a billboard that attracts my attention when I am in town. It shows a woman sitting on the back of a bicycle being ridden by a young man. The woman is heavily pregnant and seems to be in labour and being sent to wherever she will deliver her child. This can happen. Many years ago when I lived in Tamale in northern Ghana, it was quite common to see a whole live cow or several goats or a wardrobe, being transported at the back of bicycles. It is quite usual to find a pregnant woman, with a child at her back and holding one in her arms, sitting on the back of a bicycle.

The billboard says: 'Out of every 100,000 women who give birth, 350 die'. Let me tell you a little story. In the town I live in now, I have heard of two women dying during childbirth in one hospital. These women were mid to late twenties, freshly married, their first deliveries. and clearly affluent. They were not in a rural area. Their backgrounds tell me they are likely to be of good nutritional status and better ways of life. They might have taken all the precautions while pregnant because of better education and awareness. They probably attended all the antenatal clinics and were driven to the hospital in good private cars during labour. The hospital they died in is one of the best in the country. These deaths may have nothing to do with the health service delivered to them. These two examples could also be out many thousands successful births. I do not have the full story yet but one thing is clear. Maternal mortality is a significant problem, not confined to rural areas of Ghana. I hope deaths of this nature are properly reviewed, questioned and health professionals are held accountable if any negligence is reported.

The First Lady of the republic, Mrs Ernestina Naadu Mills (pictured above). is a strong campaigner for zero maternal deaths in Ghana, which is among the countries where maternal deaths were over 550 per 100,000 live births in 2005. See the map below. More recent statistics show a drop to 350/100,000 deaths (1). But compared to the European region where estimated maternal deaths for 2005 were 27 per 100,000 live births, we in Ghana have a big problem We are not making enough progress to achieve the Millennium Development Goal.



Rates of death of mothers in childbirth, 2005. As you can see, rates are very high throughout sub-Saharan Africa, including my own country of Ghana

Mrs Mills has said that the rate at which women are dying during childbirth is unacceptable. Speaking at a launch of her campaign for accelerated reduction of maternal mortality in Africa under the theme 'Ghana cares: no woman should die while giving life', she called on all to work hard to ensure zero tolerance of maternal mortality in the country. She said 'I hope to enjoy all the support for the vision of sustaining the continuity of the human race in Ghana, by ensuring that every woman in giving life stays alive, as well as the baby'. She noted that the loss of a mother shatters a family and threatens the well-being of the surviving children. She has called on metropolitan, municipal and district chief executives to draw up comprehensive programmes to reduce maternal mortality. She also said that there will be policy dialogue, advocacy, and community social mobilisation to ensure political commitment, and to bring about societal change. Industry, and non-governmental and civil society organisations and other actors, are all being encouraged to increase their efforts to accelerate reduction in maternal mortality.

In my next column I will see how the suggested solutions may work. For now I congratulate the First Lady. It is indeed fundamentally wrong for women to live all their lives healthily, only to die helplessly during child birth.

Reference

1. World Health Organization. *Global Health Observatory Data Repository*. Obtainable at http://apps.who.int/ghodata/?vid=240

African issues (1)
2011 and now – ongoing

I wrote eight columns last year. Some of the issues of 2011 are still to be dealt with because they are ongoing.

Capacity building

In February, I recounted my trip to Windhoek, Namibia, the beautiful Southern African city, where I attended the grant writing workshop organised by the African Nutrition Leadership Programme. The objective of the training was to develop young nutrition scientists in Africa to write good proposals and to make us internationally competitive. A key outcome of the training was that every one of us would submit grant proposals after the training. I will be very happy to hear from those who were part of this training, to know if they've been successful in winning any grants. On my part, I have been more active in writing articles for publication, as well as grant proposals.

Ensuring food security

When I wrote about dietary diversity in March, the key message was that diversifying food intake is important for addressing food and nutrition security in Africa, especially in remote areas. These are where there are many indigenous foods, especially fruits and vegetables, some not included in food composition tables. These foods should be researched, and promoted. So often, ultra-processed foods on the shelves of supermarkets are regarded as better and as prestigious. Many people including rural folks think that eating such products makes you 'cool'. Where I am from, it is not prestigious to grow food in your backyard or to carry a basket in an open market.

Taboos still exist

I enjoyed writing about food taboos in April. What made this topic special was because I wrote about kwashiorkor and the fact that its origin had a lot to do with food taboos. The indigenous people in Accra, Ghana, the Ga, my own tribe, used the word *kwashiorkor* because it means 'the disease of the first-born child as a result of the coming of the second-born child'. These children were suffering from

malnutrition because they had been prematurely weaned, were inadequately fed and received poor care. It took the Jamaican paediatrician Cicely Williams who worked in Accra in the early 1930s, and understood what was happening, to make it known to the medical world. Food taboos influence nutrition a lot and although the people in the Ga tribe have long ago known that kwashiorkor was a form of malnutrition, some of these taboos still exist in Africa.

Young leaders

For my May column I asked participants at the 10 annual African Nutrition Leadership Programme to share testimonies with readers after their training. Ali Jafri said: 'Before attending, I was going to give up on a community project I had started in Morocco. But during the social responsibility session, I became convinced to keep on that project because I have a responsibility to the people I serve. Through the other sessions, I understood that in order to succeed, I should share my vision with others so that they will know what I am trying to achieve and be able to support my efforts. I started that right after I came back home in Morocco'. Wow!

Protection against AIDS

July's topic was nutrition and HIV-AIDS, which compromises nutritional status and immune competency. This increases susceptibility to secondary infections. Malnutrition increases the risk of HIV-AIDS. Once infected, progression is faster in poorly nourished people.

The food crisis

In September, I touched on the food crisis in East Africa. Readers may remember the debate among the decision-makers as to who should be blamed, rather than what should be done. In fact, just thinking about this brings back the sadness I felt then.

Concerted action

Meanwhile, African nutritionists were planning for the Federation of African Nutrition Societies (FANUS) Conference, and my November column commented on the event. There was a unified interest from all Africans. For me this was an indication that things will happen. But that wasn't all. There were a lot of policy issues and action-oriented topics discussed. In fact a colleague of mine mentioned how his boss refused to attend the conference because he thought the topics were policies rather than science. I think he got it wrong. The big public health problems in Africa have little to do with science. The issues are all about governance, and policies to put the science into action.

2012 expectations
Four key decisions

Four important decisions were taken at the FANUS conference. The first was to develop common competency-based curricula. We have committed to make sure nutritionists in Africa are full professionals who need to know and also how to do. This indeed is a key step to having a well trained public health workforce that is able to change things and do things that make a difference.

The second key FANUS decision was to unite African country in implementation of the Scaling Up Nutrition (SUN) initiative. Interventions like exclusive breastfeeding for six months and continued breastfeeding thereafter, appropriate complementary feeding, and addressing micronutrient deficiencies, will reduce malnutrition levels and prevent deaths in infant and young children.

The third decision was that the younger generation of nutritionists should be more involved. They have drive, enthusiasm, motivation and passion. In the FANUS programme, younger and older participants were equally involved in deliberations and decisions.

At FANUS the fourth decision was a call for Africa to start dealing with cancer. The proposed start, is cancer registers that collect information on those who suffer from cancers, the type of cancers, and causes. Apart from smoking, food and nutrition is the second largest cause of cancer globally. We are still battling with communicable diseases in Africa, but non-communicable diseases are now prevalent.

Coming events

The Fifth African Nutrition and Epidemiology Conference is being held from 30 September to 4 October this year in Bloemfontein, South Africa. Its theme is 'Transforming the Nutrition Landscape in Africa'. It is being held conjointly with the Twelfth Congress of the Association for Dietetics of South Africa, and the 24th Congress of the Nutrition Society of South Africa. I recommend that professionals from associated sectors like water and environmental sanitation, agriculture, education, transport, human rights be invited, and also journalists, to help us advocate and communicate effectively. In Bloemfontein, we should agree on competency-based curricula for nutritionists based on the knowledge based curricula agreed at FANUS. The programme should also enable African Nutrition Societies to report on what they've done to scale up nutrition interventions.

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